



DIVISION OF DEVELOPMENTAL DISABILITIES
Olympia, Washington

TITLE: USE OF PSYCHOACTIVE MEDICATIONS POLICY 5.16

Authority: Chapter 71A RCW Developmental Disabilities
Chapter 388-820 WAC Community Residential Services and Supports

BACKGROUND

Psychoactive medications have proven to be a very effective treatment for many forms of mental illness. As with other prescription medications, psychoactive medications have the potential for unwanted side effects. Regular monitoring for side effects and evaluation of medication effectiveness is especially important for individuals who have a reduced capacity to communicate symptoms of potential side effects.

Psychoactive medications are not necessarily the first or only treatment of choice, particularly for challenging behaviors. Positive behavior support approaches may be equally or more effective and treatment decisions should always be made on an individual basis. Refer to Division of Developmental Disabilities (DDD) Policy 5.14, *Positive Behavior Support*, for more information on positive behavior support.

PURPOSE

This policy establishes guidelines for assisting a person with mental health issues or severe challenging behavior to access accurate information about psychoactive medications and treatment, and to make fully informed choices.

SCOPE

This policy applies to all persons who receive DDD certified and contracted residential services and services through DDD State Operated Living Alternatives (SOLA).

DEFINITIONS

Medication monitoring means to monitor the client's response to one or more prescribed medications. Monitoring may include observation of the client for side effects, correct dosage, intervals, and other medically approved best practice monitoring techniques.

Psychoactive medications means medications prescribed to improve or stabilize mood, mental

status, or behavior. Psychoactive medications are categorized as anti-depressants; anti-mania; anti-anxiety; anti-psychotics/neuroleptics; stimulants; and sedatives.

POLICY

Psychoactive medications are prescribed for the purpose of enabling a person to function better, reduce challenging behavior, or treat a mental illness. Persons with developmental disabilities and mental illness, and/or severe challenging behavior shall have adequate access to information and treatment with psychoactive medications, and reasonable protection from serious side effects or the inappropriate use of these medications.

If a psychoactive medication is used to treat a physical condition (e.g., sleep or seizure disorder), the requirements of the policy do not apply.

PROCEDURES

A. Assessment and Treatment Plan

1. If the person appears to be displaying symptoms of mental illness and/or serious challenging behavior, refer the person for a professional assessment. It is important to rule out any physical conditions that may be causing or contributing to the behavior. It is recommended that a psychiatrist, physician's assistant, general practitioner, or nurse practitioner (ARNP) with experience in treating people with developmental disabilities conduct this assessment.
2. Prior to the assessment, staff should prepare a psychiatric referral summary and send or take this to the treatment professional conducting the assessment. The summary should briefly describe the frequency and severity of the person's symptoms or behaviors and what has been tried previously. See Attachment A for sample form, *Psychiatric Referral Summary*.

Note: Some individuals may prefer to visit their treatment professional independently and without the assistance of residential agency staff. In such cases, the person's choice should be respected and documented in the person's file.

3. After the assessment, if the treatment professional recommends psychoactive medication, the prescribing professional or agency staff should document this in the person's treatment plan. See Attachment B for sample form, *Psychoactive Medication Treatment Plan: Introduction of New Medication*. The plan should address the following:
 - a. A mental health diagnosis or a description of the behaviors for which the

- medication is prescribed;
- b. The name(s) and purpose(s) of the medication(s);
 - c. The length of time considered sufficient to determine if the medication is effective;
 - d. The behavioral criteria to determine whether the medication is effective (i.e., what changes in behavior, mood, thought, or functioning are considered evidence that the medication is effective); and
 - e. The anticipated schedule of visits with the prescribing professional.
4. Informed consent for administration of the medication by the person or his/her legal representative, if applicable, should be obtained and documented on a form that lists justification for the use of the medication. See Attachment C for sample form, *Consent for Use of Psychoactive Medication*.
- a. An information sheet on the medication(s), including potential side effects and adverse drug interactions, should be attached to the consent form. It is acceptable to use the written information supplied by the dispensing pharmacy.
 - b. Agencies should retain a copy of the consent form that is mailed to the person's legal representative in the person's file.
 - c. If the person's legal representative refuses to give consent, the agency should encourage the legal representative to meet with the treatment professional to discuss the medication issue.
5. There may be situations in which a person's legal representative is unavailable to provide consent. Where, in the physician's opinion, no significant risks are associated with the medication, the agency should act in the person's best interest and assist the person in obtaining and taking the medication. Attempts to gain consent from the person's legal representative must still be actively pursued and documented.
6. If positive supports have been identified that will assist in the treatment, reduction, or elimination of the person's symptoms or behaviors, these should be documented in a written plan such as the Behavior Support Plan (BSP), Psychoactive Medication Treatment Plan (PMTP), Individual Service Plan (ISP), or the Individual Instruction and Support Plan (IISP).

B. Monitoring Psychoactive Medications

1. The agency must monitor the person to help determine if the medication is being effective based on criteria identified in the treatment plan. If the medication appears not to have the desired effects, the agency must communicate this to the prescribing professional.
2. The agency must observe the person for any changes in behavior and/or health, which might be side effects of the medication, and inform the prescribing professional of any concerns.
3. The agency should request that the prescribing professional see the person at least every three (3) months unless the prescribing professional recommends a different schedule. The visitation schedule must be documented in the person's plan.
4. The prescribing professional should assess annually the continued need for the medication. See Attachment D for sample form, *Psychoactive Medication Treatment Plan: Annual Continuation of Medication*.

EXCEPTIONS

Any exceptions to this policy must have the prior written approval of the division director.

SUPERSESSION

DDD Policy 5.16
Issued July 1, 2001

DDD Policy 5.16
Issued May 26, 1999

DDD Policy 5.16
Issued January 30, 1996

Approved: /s/ Linda Rolfe
Director, Division of Developmental Disabilities

Date: 11/1/03

PSYCHIATRIC REFERRAL SUMMARY

Client Name: _____ DOB: _____ Age: _____ Gender: M F

Address: _____

Supporting Agency: _____

Contact Person: _____ Phone: _____

Legal Representative: _____ Phone: _____

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

DDD Case Manager: _____ Phone: _____

Form completed by: _____ Date: _____

Relationship to client: _____

Briefly describe why this person is being referred for a psychiatric evaluation:

Symptom(s) or behavior(s) of concern (define and state frequency and severity of each symptom or behavior):

Previous mental health involvement (list past counseling, behavioral interventions, diagnoses, medications, psychiatric hospitalizations, crisis team contact, etc.):

PSYCHIATRIC REFERRAL SUMMARY (continued)

List other agency contacts and phone numbers (employment, vocational, mental health, other therapists, etc.):

What has been tried previously (list intervention and results, if known):

List diagnoses/medical concerns:

Current medications and daily dose:

List any known unusual or adverse reactions to medications:

Describe the following characteristics of the person (if not already listed):

Sleep pattern _____

Mood/affect _____

Eating/appetite _____

Thinking/cognition _____

Memory _____

Anxiety level _____

Hyperactivity _____

Sensory impairments _____

Allergies _____

Gynecological problems _____

PSYCHIATRIC REFERRAL SUMMARY (continued)

Urinary problems _____

Communication impairment _____

Other Information that may be pertinent:

**PSYCHOACTIVE MEDICATION TREATMENT PLAN
INTRODUCTION OF NEW MEDICATION**

Name: _____ DOB: _____ Date: _____

Address: _____

Supporting Agency: _____ Phone: _____

Diagnosis and/or description of behavior for which medication is prescribed:

Medication(s):

Dosage:

Length of treatment trial (considered sufficient to determine if medication is effective):

Behavioral criteria to evaluate effectiveness of medication (what changes in behavior, mood, thought or functioning should be expected):

Schedule return visit in: _____

Prescribing Physician

Agency Staff

CONSENT FOR USE OF PSYCHOACTIVE MEDICATION

Name: _____ DOB: _____ Date: _____

Medication for which consent is requested: _____

Purpose for which medication is prescribed:

Information on medication: see attached information sheet that describes the medication, dosage ranges, and possible side effects.

Questions regarding the use of this medication should be addressed to the prescribing physician listed below.

Physician: _____ Phone: _____

Consent Statement:

I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered. I consent to the use of this medication. I understand that failure to consent to this medication will not result in loss of services from the Division of Developmental Disabilities (DDD). I also understand that I may withdraw my consent at any time, without loss of services from the Division of Developmental Disabilities.

Signature of Client

Date

Signature of Client's Legal Representative

Date

**PSYCHOACTIVE MEDICATION TREATMENT PLAN
ANNUAL CONTINUATION OF MEDICATION**

Name: _____ DOB: _____ Date: _____

Address: _____

Supporting Agency: _____ Phone: _____

Diagnosis and/or description of behavior for which medication is prescribed:

Medication(s):

Dosage:

_____	_____
_____	_____
_____	_____
_____	_____

Positive results of this medication and justification for continuation:

Plan to continue use of this medication:

Schedule return visit in: _____